

# Washington, D.C. Home Health Aide Program

## NNAAP® EXAMINATION APPLICATION

PLEASE PRINT LEGIBLY — USE INK ONLY



This registration form must be completed if you wish to take the NNAAP® Examination. You are responsible for completing the form. You may ask your employer or someone from your training program for assistance in completing the form. The personal information will only be used to determine your eligibility to test. Failure to provide complete and accurate information may delay your nurse aide test or prevent your entry on the DC Home Health Aide Registry.

**1. PERSONAL INFORMATION** Enter the requested information on the appropriate line. Enter your name as you would like it to appear on your nurse aide registration. An identification number is needed to process your application. If you do not have a Social Security number, please check the box below. By checking the box as indicated you are acknowledging that you would like a nine-digit number to be assigned for Registry purposes.

Social Security Number:    -   -

☐ I don't currently have a Social Security Number. I understand that I will be required to have a Social Security number within my two-year certification period.

Date of Birth:   /   /

Gender: ☐ FEMALE ☐ MALE

**CURRENT Legal Name: DO NOT USE NICKNAMES**

LAST

FIRST

MI

**MAIDEN Name: (if applicable)**

**Mailing Address:**

STREET (number and name)

CITY

APARTMENT NUMBER

PO BOX

STATE

ZIP CODE (MUST be completely filled out)     -

Home Phone Number:    -    -

AREA CODE

Work Phone Number:    -    -

AREA CODE

**Ethnic Group (optional). Please mark only one.**

☐ American Indian/Alaskan Native

☐ Black (Non-Hispanic)/African American

☐ Hispanic

☐ Asian American

☐ Caucasian (Non-Hispanic)

☐ Other

**2. EXAMINATION TYPE AND FEES (check only one box)**

Check the box indicating the exam that you need to take. If you are applying for first time, you must take both the Written (or Oral) Examination and the Skills Evaluation. You must choose between the Written Examination and the Oral Examination; you may not register for both. (For more information about the Oral Examination, refer to the District of Columbia Nurse Aide Candidate Handbook.)

- ☐ Written Exam and Skills Evaluation (**first-time**) ..... \$105.00
- ☐ English-Oral Exam and Skills Evaluation (**first-time**) ..... \$105.00
- ☐ Written Exam and Skills Evaluation (**re-test**) ..... \$105.00
- ☐ English-Oral Exam and Skills Evaluation (**re-test**) ..... \$105.00
- ☐ Written Exam **ONLY** ..... \$40.00
- ☐ English-Oral Exam **ONLY** ..... \$40.00
- ☐ Skills Evaluation **ONLY** ..... \$65.00

Amount enclosed : \$    .

**Examination fee:** Must be paid in the form of a certified check, company check, or money order, made payable to "American Red Cross" (ARC). No personal checks, cash, or credit cards accepted. Fees are non-refundable once submitted because they cover the administration costs of registration and testing.

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**3. ELIGIBILITY ROUTE INFORMATION** (check only one box)

- ☐ H1 – I have completed an approved DC Home Health Aide training program within the last twenty-four (24) months.
- ☐ I have enclosed a photocopy of my home health aide training completion certificate, issued within the last twenty-four (24) months by an approved DC home health aide training program.

HHA Training Program Code:

Date Completed Training :   /   /

- ☐ H2 – I am a CNA and have completed the Home Health Aide bridge course.

CNA Registry Number: 

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**CNA Expiration Date:**   /   /

HHa Training Program Code: 

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Date Completed Training : 

M	M

 / 

D	D

 / 

Y	Y	Y	Y

- ☐ H3 – I completed an approved Nursing Assistant course and a Home Health Aide bridge course but have not tested.

- ☐ I have enclosed a photocopy of my Nursing Assistant Training Program Certificate.

- ☐ I have enclosed a photocopy of my Home Health Aide Training Program Certificate.

- ☐ H4 – I am currently a Student Nurse or LPN or RN licensed in D.C.

- ☐ I have enclosed a photocopy of my student nurse transcript showing Fundamentals of Nursing completed.

- ☐ I have enclosed a photocopy of my RN or LPN license.

- ☐
- H5 – I trained as an RN or LPN outside the United States.

- ☐ I have enclosed a photocopy of my CGFNS certificate issued within the last 36 months.

- ☐ H6 – I am taking the NNAAP® Examination for re-application to become current on the Registry after lapsing. My Registry Certificate expired *within* within the last twenty-four (24) months.

- ☐ I have enclosed a photocopy of my expired Registry Certificate.

- ☐ H7 – I am taking the NNAAP® Examination for re-application to become current on the Registry after lapsing. My Registry Certificate expired *more than* twenty-four (24) months ago and I have completed an approved Home Health Aide training program.

Name of Training Program:

Training Program Code: 

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Training Program Completion Date :   /   /

**PLEASE REVIEW YOUR APPLICATION. BE SURE IT IS CORRECT AND ACCURATE. IF YOUR FORM IS INCOMPLETE, OR YOU HAVE NOT ENCLOSED THE CORRECT EXAMINATION FEES, OR YOU HAVE NOT ATTACHED A COPY OF THE REQUIRED DOCUMENTATION, YOUR APPLICATION WILL BE RETURNED TO YOU. THIS WILL DELAY YOUR REGISTRATION. THE AMERICAN RED CROSS IS NOT RESPONSIBLE FOR MISDIRECTED MAIL.**

**6. REGISTRANT CERTIFICATION** I hereby certify that the information provided on this registration form is true and accurate, and that I am the person whose name appears on the form.

SIGNATURE

DATE \_\_\_\_\_

**Mail your completed application, including all required documentation and fees to:**

**American Red Cross**  
1804 North Sixth Street  
Harrisburg, PA 17102

**For test scheduling inquiries, please call: (888) 399-7729.**